

ASSISTED LIVING STRATEGIES TO ENHANCE RESIDENT CARE



STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
Bureau of Assisted Living

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Note: *The approaches identified in this document are not mandatory. They are proven approaches that may be useful in helping your facility sustain compliance.*

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Assisted Living Strategies to Enhance Resident Care

BACKGROUND INFORMATION

In recent years the Bureau of Assisted Living developed recommended practices and strategies to help providers avoid being issued any of the “Top 10” citations most frequently issued to adult family homes (AFHs), community-based residential facilities (CBRFs), and residential care apartment complexes (RCACs).

In continued efforts towards promoting regulatory compliance in Wisconsin assisted living facilities, the Bureau of Assisted Living has developed strategies designed to help providers avoid the types of serious violations that generally result in enforcement action. Serious violations are deficiencies that have affected or may adversely affect the health, safety, or welfare of residents.

During the calendar year 2013, 21 percent of surveys resulted in deficiencies with enforcement and 9.3 percent of regulated entities were responsible for 100 percent of the sanctions issued.

Violations subject to enforcement include those that:

- ***Create a condition or occurrence that presents a substantial probability that death or serious mental or physical harm to a resident will result (or did occur); or***
- ***Create a condition or occurrence that presents a direct threat to the health, safety or welfare of a resident.***
- ***Indicate a breakdown in facility systems that could contribute to serious harm or adverse consequences for residents, or create a direct threat to the health, safety or welfare of a resident or residents.***

Failure to provide services that contribute to actual or potential negative resident outcome (harm) often stems from a lack of assessment and planning. Ensuring comprehensive pre-admission and ongoing assessments and developing individualized service plans can be an effective means for avoiding serious negative outcomes for residents of assisted living facilities.

The chart below shows citations frequently issued in 2013.

CBRF Top 10 Citations		AFH Top 10 Citations		RCAC Top 10 Citations	
83.35(3)(d)	Service Plans Updated Annually or on Changes	88.10(3)(l)	Safe Physical Environment	13.05(3)(a)	Entity Allegation Reporting
83.14(2)(a)	Licensee Ensures Facility Complies with Laws	88.05(3)(a)	Home Environment	89.23(4)(d)1	Services – Staff Training in Safety Procedures
83.32(3)(h)	Rights of Residents: To Receive Medications	88.05(4)(d)2.b	Fire Evacuation Annual Evaluation	89.26(4)	Annual Review
83.38(1)(b)	Supervision	88.04(2)(f)	Condition which Represents Risk or Harm	89.28(1)	Risk Agreement-Requirement
83.47(2)(e)	Other Evacuation Drills	88.04(5)(a)	Training – 15 Hours within 6 Months	89.28(6)	Risk Agreement – Updating
83.38(1)(g)	Health Monitoring	88.05(2)(a)	Difficulty Walking	89.29(2)(b)2	Admission and Retention of Tenants
83.15(3)(a)	Administrator Shall Supervise Daily Operation	88.06(3)(f)	Review of ISP	89.23(2)(a)2.c	Services – Nursing Services
83.25	Continuing Education	88.04(2)(g)1	Health Screening for Staff	89.23(3)(d)	Services – Appropriate to Needs, Abilities and Preferences
83.35(3)(a)	Comprehensive Individualized Service Plan	88.05(4)(b)2	Smoke Detectors – Testing and Maintenance	89.23(4)(a)1	Services – Provider Qualifications
83.37(1)(i)	PRN Psychotropic Medications	88.05(4)(d)2.a	Fire Safety Evacuation Plan Review	89.23(4)(a)2	Services – Nurse Qualifications

FALLS – 2013 SERIOUS VIOLATIONS

The following are examples of violations with enforcement which resulted in negative outcomes for residents. For the purpose of this document, we will focus on examples with residents found to be at risk for negative outcomes from falls, challenging behaviors, and elopement. However, it is important to note that many other problems stem from a lack of assessment and planning. The examples include assessment and service plan approaches that may have prevented the serious consequences experienced by the residents.

Examples:

The provider did not conduct an assessment of possible safety risks or ensure proper installation prior to permitting the use of a Bed Valet (bed rail) for a resident with dementia and mental status change. The resident died from accidental strangulation after falling and becoming entangled in the bed rail. The medical examiner's report described brain death due to compromised blood flow through the carotid arteries. The resident's body and covers were noted to be on the floor while the resident's head was caught in the Bed Cane/Valet.

Over a period of 4 months, a resident experienced a decline in ambulation with 12 falls, including falls with injury. The facility did not assess the resident's safety needs or incorporate interventions to prevent injuries. The resident eventually fell and sustained a head laceration and a large intraparenchymal hemorrhage (bleeding within the brain). The resident died due to the injuries sustained in the fall.

Problem

Resident Falls in Assisted Living

There are many factors that can cause a person to be at high risk for falls resulting in injury. A few risk factors that may contribute to falls include:

- poor mobility (balance problems, muscle weakness);
- diseases and long-term illnesses (Parkinson's, Osteoporosis, high/low blood pressure);
- vision problems;
- medication side effects;
- fear of falling;
- environmental/situational hazards (poor lighting, in a hurry, no handrails on stairs/in the bathroom, unsecured rugs); and
- clothing/ footwear.

An example may be a person with impaired cognition and poor eyesight not remembering to call for assistance prior to standing or getting out of bed to go to the bathroom.

Goal

To prevent/reduce incidents of resident falls and injuries related to falls.

Approaches

1. Conduct a thorough fall risk assessment of all individuals prior to admission to the facility or when there is a change in the resident's condition that may increase the risk for falls.
2. The assessment should include important components such as chronic conditions, including arthritis, diabetes, stroke, Parkinson's, incontinence, and dementia; lower body weakness; gait and balance problems; psychoactive medications; behavior issues; postural dizziness; poor vision; problems with feet/shoes; and a history of falls.
3. Determine if the resident may benefit from a physical therapy evaluation or adaptive equipment and pursue with the resident's physician.
4. Ensure that the facility has the capacity and capability to provide the appropriate environment and level of supervision to meet the needs of the individual at risk for falls.
5. Develop a written falls policy and procedure that directs staff on how to respond if a resident falls. The plan should include the type of assessment or body check to be completed; medical attention, if needed; who should be notified; and what needs to be included when documenting the incident.
6. Communicate and instruct staff about the resident's level of risk for falls, supervision, and care needs.
7. Address the resident's fall risk in the resident's Individualized Service Plan (ISP).
8. If a resident has fallen, investigate the circumstances related to the fall to determine if additional approaches need to be put in place. Try to determine as much of the "who, what, when, where and how" of the incident as possible:
 - Where did the resident fall?
 - How did the resident fall? (environmental hazards?)
 - When did the fall occur? (Determine the lighting at the time of the fall.)
 - What was the resident doing when the fall occurred?
 - What was the resident wearing? (Nonslip footwear? Pants that were too loose, causing the resident to hold onto the walker with one hand and holding up the pants with the other?)
 - Was there a recent change to the resident's medications?

9. Review the possible continued risk to determine:
 - If the resident had previous falls.
 - If the resident could benefit from physical and/or occupational therapy.
 - If the resident needs an increased level of supervision during certain tasks.
 - If there are common factors that can be attributed to a pattern of falls and what changes could be made to prevent further falls.
10. Clearly identify in the ISP the resident's needs and approaches to prevent or reduce the risk of falls. Communicate these interventions to staff.
11. If there is general increase in falls or injuries throughout the facility, track the falls and injuries facility-wide to determine if there may be a systemic issue, such as residents falling at certain places within the facility because of traffic patterns, staffing patterns, etc.
12. Ensure staffing levels are adequate to meet the care and supervision needs for each resident at risk for falls.

Top 10 Citations Issued

The top 10 citations issued related to falls include:

- CBRFs – 83.32(3)(h), 83.35(3)(a), 83.35(3)(d), 83.38(1)(b), 83.38(1)(g)
- AFHs – 88.04(2)(f), 88.04(5)(a), 88.05(2)(a), 88.06(3)(f)
- RCACs – 89.23(3)(d), 89.23(4)(a)1, 89.26(4), 89.29(2)(b)2

CHALLENGING BEHAVIORS – 2013 SERIOUS VIOLATIONS

Examples:

Over a period of five months, the provider retained a resident who was abusive to three other residents without providing adequate behavioral interventions. The resident would “spit, hit, throw things, takes things from other residents and urinate on them...” At times the resident was found “covered in blood” or with “smeared feces all over the room and his/her body.” Residents in the home expressed ongoing feelings of fear and intimidation.

The provider failed to protect vulnerable residents after admitting a physically aggressive resident to the facility. The resident (who was a former boxer) hit another resident (who had dementia) several times, requiring police intervention. During a subsequent incident, the two residents were in the parking lot unsupervised when the second resident was punched in the face. The resident fell to the ground, hitting his/her head on concrete. The resident was taken to the hospital and diagnosed with a subdural hematoma and later died from "complications from a closed head injury – Homicide." The facility retained the aggressive resident without providing additional supervision or services to ensure the protection of others.

Problem

In assisted living facilities, residents with dementia, developmental/intellectual disabilities, emotional disturbance, mental illness or traumatic brain injury often develop behaviors that create risk to themselves and others. There are also examples of behaviors manifested because of medical, mental and physical conditions that may not be physically or environmentally dangerous but difficult and challenging to handle. Thorough behavioral assessments are needed in order to develop supportive and therapeutic strategies that can be used by caregivers within assisted living settings.

Goal

To provide a safe and positive home-like environment for all residents, respecting the residents' rights to live in a least restrictive environment through initial and ongoing assessments and development of supportive behavior programs and supervision plans.

Approaches

1. Prior to admission, do a thorough assessment of the individual. Information should include: physical health; medications; presence and intensity of pain; nursing procedures; mental and emotional health; behavior patterns that may be harmful to the individual or others (including destruction of property); risks such as choking, falling, and elopement; capacity for self-care and self-direction; activities within the community; and information about the individual's family. Any behavior assessment or plan previously developed and used for the individual

should be included for reference. Assessment information should include available information from the individual's whole care team, including the delegated representative(s), case manager(s), behavior specialist(s), county clients' rights specialist(s), caregiver(s), physician(s) and mental health specialist(s).

2. Develop a supportive behavior program and supervision plan based on the information gathered through the assessment. Develop a behavior crisis plan to be implemented if necessary. Some behavior/supervision plans for residents with developmental/intellectual disabilities and traumatic brain disorder are reviewed through the Department of Health Services (DHS) Oversight Committee for Restrictive Measures. All individual behavior/supervision plans are developed in conjunction with a resident's care team, and if there is a concern that the plan may appear to be too restrictive, the behavior program can be reviewed by the county clients' rights specialist and/or DHS Oversight Committee for Restrictive Measures. Important elements of the plan would include:
 - Identifying the resident's daily routine for personal cares and scheduled activities in the residence and the community.
 - Identifying any "triggers" that lead to aggressive/challenging behaviors.
 - Identifying other factors that coincide with the behaviors such as time of day, environmental disturbances, care needs, medical/physical needs, interaction with staff or other residents.
 - Identifying in the ISP each resident's supervision needs and specific approaches to meet those needs.
 - Ensuring staffing levels that provide for the safe and complete supervision of residents with behavioral needs as well as the ability to provide for the care needs for all of the residents living in the facility.
 - Ensuring that if an as-needed psychotropic medication (PRN) is prescribed as part of a resident's supportive behavior program, the facility provides current documentation about PRN psychotropic medications as part of a resident's behavior plan.
 - Ensuring PRN medication use will be monitored and documented according to medication administration standards and physician orders are part of the resident's record.
 - Ensuring the behavior support plan includes the reason for administering the medication, the effectiveness of the medication, and any negative effects of the medication. See guidelines contained in DHS 83.37(1)(h) and (i).
 - Ensuring that the facility maintains an adequate alarm system as required by behavior/supervision/crisis plans.

- Ensuring that written emergency/crisis plans for individual residents are in place to direct the caregivers' response and actions for behaviors that are unsafe, threatening and beyond the scope of care within the facility; the procedures should include when to contact a crisis unit, law enforcement, caseworkers, and guardians or activated powers of attorney.
- Documenting staff training on residents with behavioral challenges. Review individual approaches and strategies with caregivers and provide instruction on documentation of behaviors.
- Providing and documenting staff training on emergency/crisis plans for individual residents.
- Ensuring the facility removes risks and provides appropriate care/supervision for all residents in the event of a behavioral incident that results in negative outcome for the resident with behavioral challenges or other residents in the home. Document the incident, the follow-up care and the contacts made.
- Ensuring that new or heightened behaviors are assessed and appropriate strategies and approaches are developed by the care team and added to the ISP, behavior program, and supervision plan. Re-instruct staff on new or changed approaches.
- Assessing each resident for progress or diminishment of behaviors on a routine basis. Continue to stay in contact with all members of a resident's care team.

Top 10 Citations Issued

The top 10 citations issued related to challenging behaviors include:

- CBRFs – 83.15(3)(a), 83.25, 83.32(3)(h), 83.35(3)(a), 83.35(3)(d), 83.37(1)(i), 83.38(1)(b), 83.38(1)(g)
- AFHs – 88.04(5)(a), 88.06(3)(f)
- RCACs – 89.23(3)(d), 89.23(4)(a)1, 89.26(4), 89.29(2)(b)2

ELOPEMENT – 2013 SERIOUS VIOLATIONS

Examples:

The police found a resident wandering in a neighborhood, ringing doorbells. The resident had fallen and “appeared extremely disheveled with grass/dirt stains on pants and shoes on the opposite feet...did not know where [s/he] lived and complained of head pain and discomfort from being out in the cold for an unknown, extended period of time.” When police contacted the CBRF, the caregiver on duty was not aware the resident had been missing. Police “informed the caretaker of [the resident’s] whereabouts and condition.”

A resident with advanced Alzheimer’s disease did not receive adequate supervision and left the facility undetected in frigid temperatures (a low of 7 degrees). The resident was wearing only slacks, a shirt, and slippers. Although the resident required scheduled checks of his/her whereabouts, caregivers did not check on the resident after 1:00 a.m., and s/he was discovered deceased outside at 8:05 a.m.

Problem

Resident Elopements in Assisted Living

Persons with dementia are at high risk of harm due to eloping from assisted living facilities. Hazards such as inclement weather, temperature extremes, bodies of water, and traffic can all pose safety risks for this vulnerable population.

Goal

To prevent resident elopements and maintain resident safety.

Approaches

1. Conduct a thorough assessment of all individuals prior to admission to the facility. The assessment should include important components such as confusion and other symptoms of cognitive impairment that could cause exit-seeking behavior. Determine if the individual has a history of exit-seeking behavior. Ensure that the facility has the capacity and capability to provide the appropriate services to meet the needs of the individual at risk for elopement.
2. Develop a preventative action plan for residents at risk for elopement. Important elements of your plan would include:

- Observing the location of each resident at risk for elopement and determining the needed schedule for monitoring.
 - Determining the triggers for each resident at risk for elopement that may cause the exit-seeking behavior (time of day, thirst, hunger, activity, pain, staff interaction, change in bowel habits, fear, etc.).
 - Identifying in the ISP each resident's supervision needs and approaches to meet the needs.
 - Ensuring staffing levels are adequate to provide supervision for each resident at risk for elopement.
 - Maintaining current photographs of residents at risk for elopement and keeping the photographs in a central location, such as a medication administration book.
 - Maintaining any alarm system that the facility utilizes to alert staff of a possible elopement. Develop a schedule for monitoring the alarm system to ensure that it is operating correctly, and monitor staff response to a door alarm ringing.
 - Developing a written emergency plan that directs staff on how to respond to a resident elopement. The plan should include how the search for the resident is to be conducted both on and off the facility grounds; the procedure should provide specific times the police or family members should be notified.
 - Communicating to staff the risks for elopement, location of resident photographs, supervision needs, how to ensure the alarm system is working, and the importance of quickly responding to a resident elopement.
 - Keeping resident assessments and ISPs current and up to date.
3. Evaluate the “who, what, where, and how” of an elopement incident. Determine what interventions should be added or changed to prevent any future elopements. Update the resident's ISP to include the interventions and communicate the interventions to staff.
4. Assess for any change in condition related to exit-seeking behavior on a routine basis.

Top 10 Citations Issued

The top 10 citations issued related to elopements include:

- CBRFs – 83.15(3)(a), 83.25, 83.32(3)(h), 83.35(3)(a), 83.35(3)(d), 83.37(1)(i), 83.38(1)(b), 83.38(1)(g)
- AFHs – 88.04(2)(f), 88.04(5)(a), 88.05(3)(a), 88.06(3)(f)
- RCACs – 89.23(3)(d), 89.23(4)(a)2, 89.26(4), 89.29(2)(b)2

SUMMARY

Incidents of falls, challenging behaviors, and elopement can result in serious harm to residents of assisted living facilities. These incidents can be avoided with adequate assessment, supervision, and development/implementation of individualized plans.

The assessment process begins before a resident comes to the assisted living facility, and is done upon admission, and continues throughout the resident's stay. Pertinent and key information can be gathered from a variety of sources, including the resident and the resident's family members, friends, caregivers, medical records, social history, and other health care providers.

The goal of assessment is to answer the simple question, "Why?" Why is the resident falling? Why is the resident acting out? Why is the resident trying to leave the facility? Disruptive, disturbing, and unsafe behaviors are an indication of an unmet need.

Individualized planning is also an ongoing process. While falls, challenging behaviors, and elopement incidents are common concerns in assisted living facilities, a "one-size-fits-all" approach is not effective.

The goal of an individualized plan is to answer the simple question, "What?" What can be done to help prevent negative outcomes stemming from a resident's risk for falls, unsafe behaviors, and elopement? What approaches and supports can be provided to ensure safety of residents while maintaining dignity and consideration of their individuality?

Serious violations resulting in negative outcomes can be devastating not only for the affected residents, but can have lasting consequences for family members, caregivers, and a facility's reputation. While the percentage of facilities issued deficiencies with enforcement was less than 10 percent in 2013; the potential for violations resulting in harm to residents is great if systems for ensuring thorough and ongoing assessment and planning for residents are not maintained.

RESOURCES

Behaviors / Elopement

- Utilize the department's web-based Medication Management resource:
http://www.dhs.wisconsin.gov/rl_DSL/MedManagement/asstlvgMMI.htm
- Review information regarding person-centered planning:
<http://www.ilr.cornell.edu/ped/tsal/pcp/index.html>
- Be knowledgeable regarding current standards of practice. See list (not inclusive) of resources related to standards of practice at:
http://www.dhs.wisconsin.gov/rl_DSL/Providers/resources.htm
- DQA Memo 10-009: Elopement guidelines for Assisted Living facilities:
http://www.dhs.wisconsin.gov/rl_DSL/Publications/10-009.htm

Falls

- Utilize the department's web-based Medication Management resource:
http://www.dhs.wisconsin.gov/rl_DSL/MedManagement/asstlvgMMI.htm
- Additional information is available on the following websites:
http://www.cdc.gov/ncipc/preventingfalls/CDC_Guide.pdf
http://www.cdc.gov/homeandrecreationalafety/images/cdc_guide-a.pdf
http://www.dhs.wisconsin.gov/health/injuryprevention/pdffiles/FINAL_BOF_080210.pdf